Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 8-11-10
Amount $900.-

Ck #03054

I. IDENTIFICATION

Name LP Bedford LLC, DBA Signature Healthcare of Trimble County

Address 50 Shepherd Lane

City/County/Zip Bedford, Trimble, 40006-8809

Telephone number 502-255-3244

Administrator Francis Charles Stahl

Date facility operation began at current address —

Date facility began operation under current owner 6/1/2008

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled		
Nursing Home		
Nursing Facility	60	60
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State	(Profit)	Individual
County	Nonprofit	Partnership
City		Corporation
(Private)		(LLC)

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

N/A

(OVER)

8/31

If facility owned or leased by a corporation, complete the following:

Name of corporation LP Bedford, LLC

Address of corporation 2979 PGA Blvd Palm Beach Gardens, FL 33410

President or Chairman N/A

Vice President N/A

Secretary N/A

Treasurer N/A

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility. N/A

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation. N/A

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner. N/A

Name and address of parent corporation and/or management company, if applicable.

Parent
LP CS Holdings, LLC
2979 PGA Blvd
Palm Beach Gardens, FL 33410-2911

Management Company
Signature Consulting Services, LLC
2979 PGA Blvd
Palm Beach Gardens, FL 33410-2911

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Signature of authorized representative	Title	Date
	CFO	8/5/10

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)